A COMPREHENSIVE STUDY OF DUAL DIAGNOSIS AND COUNSELING CLIENTS WITH CHEMICAL DEPENDENCY AND DEPRESSION

by

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A Research Paper
Submitted in Partial Fulfillment of the
Requirements for the
Master of Science Degree
in

Guidance and Counseling: Mental Health Concentration

Approved: 2 Semester Credits

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May, 2007

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Title: ***A Comprehensive Study of Dual Diagnosis and Counseling Clients with Chemical Dependency and Depression***

Graduate Degree/ Major: Master of Science Degree in Guidance and Counseling: Mental Health Concentration

Research Advisor: **Dr. Gary Rockwood, Ph. D.**

Month/Year: **May, 2007**

Number of Pages: **51**

Style Manual Used: **American Psychological Association, 5th edition**

ABSTRACT

The purpose of this study was to examine current research regarding dual diagnosis. With the prevalence of dual disorders in today's society, it is essential for mental health counselors to be familiar with the specific issues faced by the dual disordered client. Research has found an integrated treatment approach to be effective with dual disordered clients when using psychotherapeutic strategies and a variety of counseling interventions. This study was focused on the following areas: history of dual disorders, assessment and diagnostic criteria for depression and chemical dependency, three perspectives for counseling clients with depression and chemical dependency, and the integrated treatment of dual disorders. The literature review revealed the need for counselors to maintain research and clinical experience in the areas of functioning affected by chemical

dependency and depression. It is recommended that additional research be completed in the area of dual diagnosis in order to examine the effectiveness of integrated treatment programs over time. Finally, recommendations were made for counselors working with dually disordered clients.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

There is an increasing awareness and level of research regarding dual disorders. The term dual disorder describes the condition of co-occurring chemical dependency and an emotional or psychiatric disorder. As a result of the high prevalence and serious consequences of these disorders, they have received considerable recognition over the past two decades (Mercer, Mueser, and Drake, 1998).

Recognition of the problem of dual disorders has led to the integration of mental health and chemical dependency programs. Traditional programs treating chemical dependency greatly contrast with those treating mental health issues. Therefore, treatment models for dual disorders focus on new methods and interventions that recognize and address both conditions in this population.

With the prevalence of dual disorders in today's society, it is essential for mental health counselors to be familiar with the specific issues faced by the dual disordered client. Counselors need to develop new intervention and treatment strategies in order to provide effective and comprehensive care for the dually disordered population.

New treatment interventions and integrated programs began in 1984 at a New York State outpatient psychiatric facility in order to address the needs of severely mentally ill chemical abusers. In 1985, these integrated programs were implemented across multiple program sites (Sciacca, 1991). "In September of 1986, the New York State Commission on Quality Care (CQC) released the findings of 18 months of research describing a downward spiral and detachment of dually diagnosed individuals who were bounced among different systems with no definitive locus of responsibility" (Sciacca, 1991, p. 72). In 1987, Time magazine revealed that at least 50 percent of the 1.5 - 2.0

million Americans with severe mental illness abuse illicit drugs or alcohol as compared with the 15 percent of the general population. It was this finding that brought the "double troubled" to the attention of the general public. New treatment interventions have evolved in order to adapt to the needs of the dually diagnosed population.

People with dual disorders vary greatly in many ways including: number and types of diagnoses, severity of substance abuse and extent of psychiatric impairment, the number and types of psychosocial problems, availability of social support systems, levels of motivation, and personal strengths (Daley & Moss, 2002). There are also distinguishable subgroups among individuals with dual disorders. These subgroups include those with a primary mental illness who also meet the criteria for chemical dependency or whose occasional use of alcohol or drugs cause problems serious enough to warrant treatment. This group includes clients who have recurrent or chronic forms of mental illness as well as those who experience one or two acute episodes. The second group includes those with a primary chemical dependency diagnosis that also experience psychiatric problems. The third group includes those with histories so complex that it is difficult to determine which diagnosis is primary. Members of this group often exhibit severe problems caused by or exacerbated by either of their disorders (Daley & Moss, 2002).

Dually diagnosed individuals also differ in their level of motivation, level of functioning, and success in treatment. On one end of the spectrum, there are the individuals who accept the reality of their condition, who are internally motivated to change, and who respond to treatment. On the other end of the spectrum are the persistent and chronically mentally ill people who refuse to admit they have a problem, who are not

motivated to change, who resist efforts to help them, and therefore, respond poorly to treatment (Daley & Moss, 2002). Those represented in this group enter the health care system due to pressure from outside agencies.

Statement of the Problem:

Dual diagnosis occurs when an individual is affected by both chemical dependency and mental illness. While they are separate disorders, each has symptoms that interfere with a person's ability to function. Symptoms can mask each other and overlap, which poses difficulty in diagnosis and treatment. Further, the illnesses may affect each other and each disorder predisposes relapse in the other disease. For full recovery to be attained treatment must address both disorders. Despite a great deal of research in support of the effectiveness of the integrated treatment approach for dual disorders, it is still not widely available. Quality care for clients with dual disorders requires counselors to prepare for many different areas of treatment including assessment, treatment, referral, and advocacy. The counselor also needs to be aware of all available community resources for the dual disordered client.

Purpose of the Study:

The purpose of this study is to examine dual disorders and counseling clients with depression and chemical dependency. The objectives are to provide comprehensive strategies for counselors working with dual disordered clients as well as describe the history of dual disorders, the assessment, treatment and relationship between depression and chemical dependency, and the three perspectives for counseling clients with depression and chemical dependency.

Definition of Terms:

Over time numerous terms have been used to describe dual disorders. It is essential to use a common language to avoid confusion in terminology. In order to provide the most complete understanding, the following terms are defined:

Dual diagnosis occurs when a person if affected by both chemical dependency and mental illness. Other names for this illness are co-morbid disorders, co-occurring disorders, concurrent disorders, co-morbidity, or dual disorders.

Substance abuse as defined in the DSM-IV-TR, "is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (American Psychiatric Association, 2000, p.198). Individuals who abuse substances may experience harmful consequences such as

- Repeated failure to fulfill roles for which they are responsible
- Use in situation that are physically hazardous
- Legal difficulties
- Social and interpersonal problems

Substance dependence is "a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues use of the substance despite significant substance-related problems" (American Psychiatric Association, 2000, p. 192). This maladaptive pattern of substance use includes all the features of abuse and the following additional features:

- Increased tolerance for the drug, resulting in the need for greater amounts of the substance to achieve the intended effect
- Obsession with securing the drug and with its use

- Persistence in using the drug in the face of serious physical or psychological problems

Limitations:

The limitation of this study is that current research specific to the integrated treatment approach for counseling the dually diagnosed client is still evolving.

CHAPTER 2: A LITERATURE REVIEW

Introduction

The co-occurrence of alcoholism with other psychiatric disorders has been widely recognized; the most consistently documented co-occurring disorders being other substance use, mood, anxiety, and schizophrenic disorders (Kessler, Crum, Warner, Nelson, Schulenberg, and Anthony, 1998). Depression, a mood disorder, is one of the most common mental disorders and affects up to 25 percent of women and 10 percent of men. Nearly one in nine Americans will experience a depressive episode in a given year. Many individuals with depressive disorders also meet the criteria for chemical dependency. Clinical reports and studies show that rates of all types of chemical dependency are high among individuals with depression (Daley & Moss, 2002).

The most comprehensive study of co-morbidity in severe mental illness conducted to date is the Epidemiological Catchment Area (ECA) study. According to the ECA community survey, more than 27 percent of individuals with depressive disorders also meet criteria for chemical dependency. In addition, clinical studies indicate that the prevalence of current depressive illness among people with substance use disorders ranges from 14 percent to 34 percent, and the prevalence of lifetime depressive illness among this population ranges from 35 percent to 69 percent (Daley & Moss, 2002).

An important factor regarding the prevalence and incidence rates of substance use disorder in the psychiatric populations is that it varies due to sampling location and demographic characteristics of the population. Persons with severe mental illness who are homeless, in jail, or who are assessed in an emergency room are more likely to have substance use disorders than other patients. In addition, substance use disorders are more

common in patients who are male, single, young, less educated, and have a family history of substance use disorder. To the extent that any sample of persons with severe mental illness is overrepresented among those with these demographic characteristics, patients may be more likely to have co-morbid substance use disorders (Mueser, Drake, & Noordsy, 1998). This paper will provide a brief history of dual disorders and integrated treatment programs. However, the primary focus will be on the symptomology, assessment and treatment of depression and chemical dependency, and three perspectives for counseling clients with depression and chemical dependency.

A Brief History of Dual Diagnosis and Integrated Treatment Programs

Dual diagnosis treatment interventions and integrated programs began in 1984 at a New York State outpatient psychiatric facility. These programs were adapted to address the needs of severely mentally ill chemical abusers (Gigliotti, 1986). In 1985, these integrated programs were implemented across multiple program sites (Sciacca, 1991). "In September of 1986, the New York State Commission on Quality Care (CQC) released the findings of 18 months of research describing a downward spiral and detachment of dually diagnosed individuals who were bounced among different systems with no definitive locus of responsibility" (Sciacca, 1991, p. 73). As a result of this research, Governor Cuomo designated the New York State Office of Mental Health as the agency responsible for coordinating efforts for the dually diagnosed population (Gigliotti, 1986). TIME magazine became aware of the CQC research report and began to investigate dual diagnosis treatment programs at the suggestion of the CQC. As a result of this investigation, a report was published along with statistics from the national dual diagnosis survey which revealed that at least 50 percent of the 1.5 - 2.0 million

Americans with severe mental illness also abuse illicit drugs or alcohol as compared with the 15 percent of the general population. This finding brought the "double troubled" to the attention of the general public.

The MICA Training Site for Program and Staff Development, New York Statewide was created for the purpose of attaining the vision of the governor's task force on statewide program development (Sciacca, 1987b, 1991). Training and program development were offered to state and local mental health and substance abuse providers. The state also produced a training video on the integrated treatment model. Programs for the dually diagnosed grew out of this model and it continues to be an important foundation for present programs in New York State and around the country.

In 1993, a project that included cross training and cross system program development was initiated by the state mental health and substance abuse agencies in Michigan. This program demonstrated that care across systems can be achieved with improved results and less costly services for the dually diagnosed.

In 1995, the Substance Abuse and Mental Health Services Administration funded the Managed Care Initiative to develop standards for patients being served by managed care providers. A panel of national experts was appointed for co-occurring disorders and a consensus report was generated. Minkoff's (2001) review of this report describes issues in developing adequate treatment systems for dually diagnosed patients. Specifically, treatment systems need to welcome and be accessible to dually diagnosed patients, the systems need to view both disorders as primary and treated simultaneously throughout the course of treatment, treatment must be delivered by persons with expertise in both disorders, long-term perspectives must be promoted, clients must be engaged regardless

of their level of motivation and outreach for hard-to-reach patients must be conducted. In addition, the report indicates the necessity of fiscal and administrative support, identified quality and outcome measures and established practice guidelines.

In summary, the history of dual diagnosis and programs indicates an increasing awareness of dual disorders and great strides in the development of effective interventions for clients with dual disorders. Over the past few decades there has been an effort to improve the outcomes of clients who received care in the traditional parallel service systems of mental health and chemical dependency treatments. There continues to be a systems level commitment to developing evidence based programs offering integrated treatment which best meets the needs of the dually diagnosed. There is also a national consensus for continuing research and modification of service models, programs, and strategies that might yield improved outcomes for the dually diagnosed consumers and their families.

The Relationship Between Chemical Dependency and Mental Illness

There are many possible explanations for the co-occurrence between chemical dependency and depression. One of the co-occurring disorders may be caused by the other and/or there may be methodological determinants. Cause and effect within co-occurring disorders is not possible to distinguish However, Daley and Moss (2002), describe the most common patterns of interaction between chemical dependency and mental illness below:

1. *Chemical dependency increases the risk of developing a psychiatric illness.*

The ECA survey and studies of patients in chemical dependency programs strongly suggest that the odds of a chemically dependent individual having a psychiatric illness are higher than among the general population.

2. *Psychiatric illness increases the risk of developing a chemical dependency.*

Studies of patients under psychiatric care show higher rates of chemical dependency.

3. *Psychiatric symptoms may affect the onset, duration, or response to treatment of chemical dependency.*

Cloninger (1987), characterized alcoholics into two subgroups, male-limited (25 percent of sample) and milieu-limited (75 percent of sample). Members of the male-limited group appear more likely to be influenced by biological factors and to develop substance abuse problems earlier (usually before age twenty-five) than members of the other group; they are more likely to get into trouble with the law and more likely to have biological fathers who have problems with substance use and antisocial behavior. Members of the milieu-limited group are more influenced by environmental factors in developing alcoholism, and they develop at a later age.

McLellan and colleagues (1985) report that inpatients with higher ratings of psychiatric severity on the Addiction Severity Index are more likely to relapse to substance abuse than are other patients. This study also shows that psychiatric impairment has a strong relationship with relapse among opiate addicts. Patients who suffer from dual disorders receive treatment at a higher rate, and thus, have a poorer prognosis than do other diagnostic groups. Similarly, Rounsaville and colleagues (1987)

found that alcoholics who also have one or more psychiatric diagnosis have a poorer treatment outcome than do patients without a psychiatric diagnosis.

4. *Psychiatric symptoms may arise as a direct result of chronic substance abuse or withdrawal.*

Drugs and alcohol may directly impair mood or cognitive functioning. Depression, mania, anxiety, panic, or paranoia, delusions, and hallucinations are some of the specific symptoms that may result from chronic substance use or as a part of withdrawal.

5. *Symptoms of psychiatric illness may result as the indirect consequences of chemical dependency.*

Many individuals suffer tremendous personal consequences as a result of their chemical dependency. Disturbed family and interpersonal relationships, increased health problems, trouble on the job, loss of dignity, and wasted potential are common among the chemically dependent. Use of illicit drugs can lead to trouble with the legal system as well. Chemical dependency can also produce antisocial behavior such as selling drugs, stealing to support an addiction, and/or aggression toward others as a result of impaired judgment.

6. *Over time, symptoms of chemical dependency and psychiatric illness may become linked or interrelated.*

In some cases, it may be difficult to distinguish which disorder is primary and which is secondary. Many of those with chronic disorders come to treatment with a very complex set of symptoms and problems. The specific symptoms may even vary from one episode to another.

7. *Each disorder can develop independently at different times.*

Alcoholics or drug addicts that have been clean and sober for many months can still develop a mental illness. It is not always easy to determine if dual disorders are present because mental illness can mask the chemical dependency, and chemical dependency can mask mental illness. Even after establishing the two diagnoses, it still may not be clear which problem to treat first. Depending on the circumstances of each case, either disorder may take precedence. Treatment must address both conditions either sequentially or simultaneously. Untreated chemical dependency may contribute to relapse of the mental illness, and untreated mental illness may contribute to an alcohol or drug relapse (Daley & Moss, 2002).

Other clinical issues of dual diagnosis indicate substance use disorders in persons with severe mental illness have been correlated with a wide range of negative outcomes. Mueser, Drake, and Noordsy (1998) cite evidence suggesting that substance abuse complicates all of the negative outcomes that frequently occur in persons with severe mental illness. Specifically, substance use disorders have been found to be associated with higher rates of relapse, hospitalization, medication noncompliance, violence, suicide, financial strains, family difficulties, HIV risk behaviors, and legal problems as a consequence of the clinical and social effects of substance use disorders in this population. Dually diagnosed clients tend to use more psychiatric services because of the high prevalence of substance use disorders in person with severe mental illness. There are wide ranging negative effects of substance abuse on the course of illness including the high cost of treatment for dually diagnosed clients. Thus, treatment of these individuals has been a high priority since the mid 1980's.

Assessment and Diagnosis of Chemical Dependency and Depression

There are several assessment issues involved with diagnosing both chemical dependency and depression. People with dual disorders are frequently misidentified because diagnosis is difficult due to one disorder mimicking the other. In order to determine a diagnosis and set appropriate treatment goals a comprehensive assessment must be completed. According to the Diagnostic and Statistical Manual Fourth Edition Text Revision (DSM IV-TR) (American Psychiatric Association, 2000) there are thirteen domains in a comprehensive clinical evaluation which include:

1. Reason for the evaluation
2. History of the present illness
3. Past psychiatric history
4. General medical history
5. History of substance abuse
6. Psychosocial and Developmental History
7. Social History
8. Occupational History
9. Family History of illness
10. Review of Systems
11. Physical Exam
12. Mental Status Exam
13. Functional Assessment

Attaining detailed information in order to adequately assess a client can be gained by using various methods such as observation, interview, questionnaires, surveys,

neuropsychological tests, physical examinations, and/or laboratory tests. The counselor completing the assessment of the client must be familiar with the American Psychiatric Association's multi-axial system of recording diagnosis as well as structured interviews and self-report questionnaires which can be used as baseline data and to track changes over time in symptoms and behaviors. In addition, interviewing family members and other concerned individuals may be able to provide important collateral details which can further assist the counselor in the assessment of the client. Lastly, as counselors for dual disordered clients it is important to be aware of the possibility that the client may have not one but two or more serious disorders and to be familiar with treatment options, community resources and effective, research based strategies for this population. In order to provide appropriate intervention and treatment it is important to be flexible and willing to assume different roles to meet the needs of the client and their family. In addition, counselors can benefit from being aware of their perceptions, attitudes and beliefs about depression and chemical dependency that may impact the ability to provide appropriate and timely care (Daley & Moss, 2002).

Assessment of Chemical Dependency

In this country, alcohol remains the number one drug of abuse, but abuse of any substance can meet the criteria for a substance use disorder. Other categories of substances include opioids, psychostimulants, depressants, marijuana, hallucinogens, phencyclidine, inhalants, and volatile or organic solvents. Many individuals use a combination of substances and thus develop patterns of poly-drug abuse and dependence. Poly-substance abuse clients are highly prone to psychiatric illness (Daley & Moss, 2002).

The definition of chemical dependency follows the criteria for substance abuse and dependence as outlined in the Diagnostic and Statistical Manual Fourth Edition Text Revision (DSM IV-TR). According to the DSM IV-TR, the grouping of substance use disorders "deals with symptoms and maladaptive pattern of substance use, leading to clinically significant impairment or distress. These behavior changes are associated with more or less regular use of psychoactive substances that affect the central nervous system. These behavioral changes would be viewed as extremely undesirable in almost all cultures" (American Psychiatric Association, 2000, p.197).

The DSM IV-TR diagnostic criteria for psychoactive substance dependence include at least three of the following symptoms which have persisted for any time in the last twelve month period:

1.) Tolerance, as defined by either of the following:

a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect.

b) Markedly diminished effect with continued use of the same amount of the substance.

2.) Withdrawal, as manifested by either of the following:

a) The characteristic withdrawal syndrome for the substance.

b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

3.) The substance is often taken in larger amounts or over a longer period than was intended.

4). There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5.) A great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain-smoking), or recovery from its effects.

6.) Important social, occupational, or recreational activities are given up or reduced because of substance use.

7.) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused by or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (American Psychiatric Association, 2000, p.197).

The criteria can be applied to abuse of substances of any type, although some symptoms will not be found with particular classes of compounds. A diagnosis of psychoactive substance abuse also applies if the individual does not meet the criteria for dependence but shows a maladaptive pattern of substance use, as indicated by one or both of the following:

a.) The patient continues to use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused by or exacerbated by use of the psychoactive substances.

b.) The patient recurrently uses in situations in which the use is physically hazardous (e.g. driving while intoxicated).

c.) Recurrent substance-related legal problems (such as arrests for substance related disorderly conduct).

d.) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (for example, arguments with spouse about consequences of intoxication and physical fights). (American Psychiatric Association, 2000, p. 181).

Substance abuse complicates almost every aspect of a person's life with depression. Many of the symptoms of substance abuse are similar to those of depression. In addition, depressed clients may self medicate to combat symptoms of their mental health disorder. In the National Co-morbidity Study, (Kessler, Berglund, Demler, Jin, and Koretz, 2003) a nationally representative population study found that participants with any substance use disorder also had a lifetime history of at least one mental health disorder. The most common diagnosis was conduct disorder (29%) followed by major depression (27%), and social phobia (20%).

Assessment of Depression

The DSM IV-TR (American Psychiatric Association, 2000) criteria for major depression includes five (or more) the following symptoms present during the same two week period, representing change from previous functioning with at least one of the symptoms being either depressed mood or loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or by observation made by others (e.g. appears tearful).

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
3. Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decreases or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without having a specific plan, or suicide attempt and a specific plan for committing suicide.

    a.) The symptoms do not meet criteria for a Mixed Episode.

    b.) The symptoms cause clinically significant distress or impairment in social, occupational, or other important area of functioning.

    c.) The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).

d.) The symptoms are not better accounted for by bereavement, (i.e. after the loss of a loved one), the symptoms persist for longer than 2 months or are characterized my marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (American Psychiatric Association, 2000, p. 356).

Once a diagnosis of substance dependence and depression has been made, the counselor begins working on a treatment plan. In order to adequately address the needs of the client and fully understand the impact of dual disorders, it is important to be aware of the various perspectives regarding dual disorders.

Three Perspectives on Depression and Chemical Dependency: Client, Family, Counselor

For the client coping with a depression life is difficult enough, yet those with depression and chemical dependency find themselves in a double bind. Certain groups, such as the chronically mentally ill, often have great difficulties with daily functioning. This group of people may be unable to find or keep a job, live independently, or develop interpersonal relationships. Many have trouble following treatment plans and are at risk of relapse. Those patients with more symptoms need additional care and are more likely to remain in treatment.

Some people with depression and chemical dependency get caught in a vicious cycle. They enter either the mental health or the chemical dependency treatment system or both. Because these patients are difficult to treat they may evoke negative reactions such as anger, frustration, and hopelessness from professionals. Those who struggle remaining clean from drugs and alcohol may be discharged from treatment even thought

they have serious psychiatric problems. These patients decompensate until they seek or are forced to get help. They can enter the treatment system again and experience the same cycle of failure and frustration (Daley & Moss, 2002).

Depression and chemical dependency either alone or in combination can create many problems for the family. The extent of the impact depends on any number of factors. These factors include: the severity of the disorders, the length of time the family has been exposed to the disorders, the behaviors of the client, the relationships between family members and the client and the family's perception of the situation (Daley & Moss, 2002).

Depression and chemical dependency can affect nearly any area of family functioning. These areas include the mood and atmosphere in the home, roles assumed by the family members, rules which operate in the family, relationships and communication among family members, cohesion, and the ability to confront and solve problems (Daley & Moss, 2002). Often, dealing with a dually disordered family member results in the family becoming tired, burned out, and hopeless.

In theory, mental health counselors are more experienced in treating clients with psychiatric problems, while chemical dependency counselors are more accustomed to treating alcoholics and drug addicts. In practice, there is a considerable degree of overlap. Both groups work with clients who have dual disorders. They often discover that their practices are not always adequate. Chemical dependency counselors must learn to recognize psychiatric disorders and deal with them in a timely manner throughout the continuum of care- in detoxification, rehabilitation, outpatient, and aftercare programs. In a similar manner, mental health counselors need to recognize and deal with clients

who have chemical dependency problems, and be prepared to offer the entire range of treatment options including support groups and Twelve Step programs (Daley & Moss, 2002).

It is important to prepare for many different areas of treatment including assessment, treatment, referral, and advocacy. Awareness of all available resources in the community such as treatment centers, self-help groups, social and case management, economic assistance, housing, and vocational training is important for the counselor. It is also important for the counselor to become familiar with procedures and community standards for voluntary and involuntary hospitalization.

Another important factor is for counselors to be aware of their own limitations. A counselor may consider not treating a client if they lack the knowledge or experience with a certain disorder. As counselors' attitudes and perceptions influence the process and outcome of interventions, they may have to modify their views of what is a success or a failure as well as set realistic and achievable goals (Daley & Moss, 2002).

Integrated Treatment, Counseling Interventions, and Recovery in Dual Disorders

Effective treatment of dual disorders integrates mental health and substance abuse intervention. Specifically, having the same clinician or team address depression and substance use issues in a coordinated effort with all intervention taking place in the same setting may lead to positive outcomes. A team of experts in co-occurring disorders has identified eight essential components to effective, evidence based dual diagnosis treatment. The eight components include stage intervention, assertive outreach, motivational interventions, active treatment counseling, social support interventions, a long-term, community based perspective, cultural sensitivity and competence, and a

comprehensive treatment system which does not isolate substance use or mental health interventions (Drake, Essock, Shaner, Carey, Minkoff, Kola, Lynde, Osher, Clark, & Richards, 2001).

There are several psychotherapeutic strategies, which are used to treat depression and chemical dependency such as interpersonal, cognitive-behavioral, dynamic, and supportive therapies. Counseling interventions address four problem areas associated with depression and chemical dependency including: dealing with feelings, changing thoughts and beliefs, changing behaviors, and participating in self-help programs.

Handling Feelings

There are a variety of counseling interventions to help clients deal specifically with their feelings and emotions. These interventions include all of the following: monitoring feelings, identifying and expressing feelings, exploring specific feelings associated with depression, and connecting feelings with thoughts and behaviors.

1. Ask clients to monitor feelings or emotions.

By keeping a journal to log feelings, the client is able to assess the severity of mood symptoms and track changes over time. This activity also shows how a person's environmental context and thoughts can contribute to their feelings.

2. Encourage clients to identify and express feelings.

Counselors may need to coach their client before they can recognize, label, and express emotions such as sadness, guilt, powerlessness, anger, emptiness, or joylessness. Counselors also need to teach clients how emotions manifest themselves in different forms such as physical ailments, thoughts, or internal messages to the self, or actions.

Once the client can identify these feelings, they can examine the causes and effects. This activity prepares the client to recognize and express feelings appropriately.

3. Help the client deal with guilt and shame.

Guilt stems from behaviors such as making hurtful statements to a spouse or failing to take an interest in a child. Shame is the feeling that one is defective or a failure. People with a dual diagnosis of depression and substance abuse typically feel intense shame and guilt. They tend to judge themselves in harsh and negative terms. Discussing these feelings and thoughts in treatment is one way to begin understanding and dealing with them. Many of the Twelve Steps of Alcohol Anonymous (Alcoholism Anonymous, 2001) address this guilt and shame. Counselors need to be ready to challenge and change these negative self-statements.

4. Help clients confront feelings of powerlessness.

Confronting feelings helps the clients to recognize what they need to do to overcome chemical dependency and life's related problems. It can be helpful to encourage clients to take these steps and give positive feedback. The counselor can use lectures, films, tapes, and readings in addition to educational counseling sessions to assist clients to explore personal issues during the counseling process.

5. Help the client deal with anger

Depression can be considered anger turned inward. Anger that has been chronically internalized helps the client rationalize their excessive chemical use. On the other hand anger can have significant negative consequences. Several ways to help the client deal with anger include:

- Encourage client to explore attitudes and believe about anger and change them as needed
- Evaluate the clients style of displaying and dealing with anger
- Evaluate the effects of this style
- Teach coping skills for dealing with anger

Cognitive, verbal and behavioral strategies have been found effective for clients dealing with anger issues. Cognitive strategies for coping with anger include learning to recognize and label anger, evaluating beliefs about anger, challenging angry thoughts with counterstatements, using fantasy, imagery, prayer or mediation, evaluating risks and benefits of anger and methods of expression, and using slogans and positive self talk. Verbal strategies include helping the client talk about angry feelings with the target of the anger or another person, talking about the situation, problem or circumstances contributing to the anger and making amends to those hurt by the anger. Behavioral strategies include walking away from situations when feeling anger or concern about losing control, redirecting anger into an activity, engaging in exercise, writing thoughts and feelings in a journal, rehearsing what to say in specific situation ahead of time, using reminder cards with positive coping statements like "stay in control", talking about the problem, and doing an anger check at the end of each day to ensure that anger hasn't been suppressed or ignored.

Clients with significant anger and rage from the past will need time and support to work through these feelings. This will require clients to get to the point of forgiving others for the perceived or actual wrongdoing they have experienced. Anger can be used as a positive tool for facing problems or improving relationships. It can be helpful to

teach clients to avoid viewing anger in only a negative way since it can also bring positive change.

6. Help the client deal with grief

Unresolved grief from many sources in a person's life may manifest itself as depression. The client may be experiencing feelings of loss due to certain events such as the life they might have had if they hadn't taken that first drink or the loss from a death in the family. Others may have never grieved because they used chemicals to avoid the grief. Coping with grief and loss is a process. The stages of grief are shock and denial, sadness, anger, examination, and acceptance of the loss. Working through emotional pain by taking part in support groups will assist the client to understanding how grief can contribute to depression and chemical dependency. The client will also find that their mood can be improved by sharing feelings, finding forgiveness, and setting limits and boundaries.

7. Help the client see the connection between feelings and behaviors and how they contribute to depression and chemical use.

It is important to point out the relationship between depression and behaviors such as the client who may feel depressed because of a lack of interpersonal relationships. The client tends to isolate when depressed and may have difficulty starting relationships due to shyness. These behaviors can contribute to depression. (Daley & Moss, 2002).

Changing Thoughts and Beliefs

Cognitive behavioral approaches have been used extensively with clients diagnosed with depression and chemical dependency. These approaches help clients to change negative thoughts and beliefs through specific problem solving or adaptive cognitive skills. According to experts in cognitive treatment, the common assumptions

that underlie a person's automatic thoughts predispose some individuals to depression (Beck, Ruch, Rush, Emory, & Shaw, 1979). Examples of depressogenic assumptions include the following:

- "In order to be happy, I have to be successful in whatever I do."
- "To be happy, I must be accepted by all people at all times."
- "If I make a mistake, it means that I am inept."
- "I can't live without you."
- "If somebody disagrees with me, it means he doesn't like me."
- "My value as a person depends on what others think of me" (Beck et al., 1979).

Cognitive therapy works to help clients understand the relationship between thoughts, styles of thinking, feelings, and behaviors. Clients learn to monitor their thoughts so they can identify and label their distorted thought and practice changing them. Counselors teach clients a technique called countering to expose and change their distorted thinking. These are the principles for countering:

- Counters must be the direct opposite of the false belief.
- They must be believable statements of reality.
- Clients should develop as many counters as possible.
- They must be created by the client (with coaching from the counselor).
- They must be concise.
- They must be stated with assertive, aggressive and emotional intensity. (McMullin & Giles, 1981).

The following are the problematic patterns of thinking identified by Beck, Ellis, and Burns (as cited by Daley & Moss, 2002, p.88) and other experts in cognitive behavioral treatment:

1. Black and white or dichotomous thinking.

Depressed clients often see things as all or none. They often show little flexibility and can't see alternatives in situations. Counselors need to help clients overcome such cognitive distortions by having them evaluate things on a continuum and in terms of degrees.

2. Seeing things as worse than they are.

Depressed clients often pay too much attention to negative details causing them to see an entire situation as negative. It is necessary to expose the irrational thinking, challenge these negative thoughts and change them to different thoughts.

3. Overgeneralizing.

Clients often use one experience to generalize to about life. The counselor can help to expose the faulty logic of generalizations and help the client to see situations in a realistic way. Words such as never and always are warnings that a client is generalizing and they need to be challenged.

4. Expecting the worst outcome (catastrophizing or magnification).

Clients suffering from depression often look at possible outcomes and expect the worst. They look at things in negative terms. Counselors need to review situations, cite all of the evidence, and examine all of the probable outcomes. It is helpful to focus on the evidence which indicates the worst case may not happen and concentrate on positive outcomes.

5. Disqualifying the positive (selective abstraction).

Clients overlook and downplay the positive side of things. They refuse to give themselves credit for their accomplishments and focus on their failures and weaknesses. In order to counteract this distortion, counselors may work to direct the focus to past and present successes, encourage them to identify personal strengths, and have them record a daily journal of positive experiences.

6. Jumping to conclusions.

Depressed clients often jump to conclusions without having all of the facts. By examining the facts and details of the situation, it is possible to overcome this distortion.

7. Emotional responses.

Clients can assume their negative emotions reflect the way things really are. Counselors may consider working with clients to overcome such distortion by looking at the difference between feelings, self-judgment, and personality characteristics. Clients need to keep in mind that feeling a certain way does not reflect a permanent part of the person's personality.

8. "Should" or "must" statements.

Clients create rigid rules for themselves that dictate their feelings and behaviors and can put them at risk of depression. These rules usually contain the words should and must. Counselors can help the client to identify, challenge, and revise these rules they have set for themselves.

9. Labeling and mislabeling.

Clients often base a negative self-image on mistakes they have made in the past. One minor negative event causes clients to negatively label themselves. In therapy, clients need to learn alternatives to these labels.

10. Personalization (self-reference).

Clients often take the blame for things that they had nothing to do with. Counselors need to appraise the situation realistically and examine the possible causes of the negative events. It can be helpful to work with the client to show them they do not need to take responsibility for all of the things that go wrong (Daley & Moss, 2002).

Changing Behaviors, Relationships, Interpersonal Style, and Lifestyle

1. Help clients identify things they want to change.

Devising a plan for change is much easier if the client identifies the specific problems or behaviors they would like to change. In the case of depression, behavior needs to change before mood will improve. Simple daily activities will decrease feelings of depression. As clients become more active, they will find that taking action becomes much easier. Successful experiences with behavioral tasks help to break the cycle of avoidance and passivity. Counselors should prepare their client for behavioral tasks by having them break the task into small achievable parts and imagine going through each step (Daley & Moss, 2002).

Lewinsohn and colleagues (1984) designed a self-change plan in their Coping with Depression course. The plan consists of the following steps:

a. Pinpoint or specify the behavior or thought to change the new skill to learn.

b. Gather information to establish a baseline for behavior.

c. Identify consequences that exist before a given behavior occurs.

d. Set attainable goals.

e. Establish a contract identifying rewards for accomplishing steps toward goals.

f. Choose appropriate reinforcers.

The counselor should work with the client to assess their personal strengths and accomplishments. It may be beneficial to offer positive feedback to the client to increase their level of self-esteem and help them to set and work toward goals.

2. Help the client change interpersonal relationships or interpersonal style.

Depression is more likely to persist in chemically dependent clients who have had problems with interpersonal relationships. The "making amends" steps of AA are a good way for the client to undo some of the damage caused by their chemical dependency. Depressed clients often feel alone in their suffering. Counselors can help them increase their level of interaction with others and emphasize the importance of social and family relationships. It is important to involve families in treatment and improve existing relationships by learning new interpersonal skills. These skills include resolving interpersonal conflicts, increasing assertive behaviors, starting and maintaining conversations, giving and receiving criticism, asking for help, providing support for others, learning appropriate ways of self-disclosure, and improving communication skills. Improving relationships gives the client a better chance of meeting their needs of love, intimacy, and friendship (Daley & Moss, 2002).

3. Help the client make other lifestyle changes.

When depressed clients are socially or physically inactive, they report an overwhelming number of self-debasing or pessimistic thoughts (Beck et al., 1979). Leisure counseling

works to develop new hobbies and recreational interests for the clients. It is helpful to work with the client to identify and schedule activities they enjoy and show how to develop and follow a weekly activities program.

Other lifestyle interventions to consider include increasing physical activity, learning relaxation techniques, and developing strategies for balancing obligations and desires. Counselors can also help the client to set realistic and attainable goals and encourage the client to reward themselves for making the efforts (Marlatt & Gordon, 1985).

Recovery and the Dual Disorders of Depression and Chemical Dependency

Recovery is the process of accepting and managing the disorders and making changes in order to reduce the risk of relapse. Treatment programs that address recovery work to educate the client about depression and chemical dependency with regard to recovery, to assist the client to find a self help program, to teach recovery skills and to manage symptoms of depression and make positive changes. The process of recovery and change depends on several factors such as the nature of the chemical dependency and depression, the presence of other medical, family or psychosocial problems, the availability of support systems as well as the interest and motivation level of the client (Daley & Moss, 2002).

Marlatt (1996) has outlined the stages of change process that is relevant to recovery. The framework details three stages of change for substance abusers: preparation, change and motivation. Preparation involves developing motivation to commit to change substance use; change involves stopping substance use and making

changes to support abstinence; and maintenance uses ongoing relapse prevention strategies.

The process of recovery addresses four major areas of functioning: physical, psychological, social, and spiritual. As previously stated, each client is different with regard to their rate of change, degree of interest and level of motivation to make change.

Physical recovery involves eliminating alcohol and drugs from the body. If clients are unable to stop using on their own, detoxification is needed. Detoxification is also needed if the client develops medical or psychiatric symptoms associated with addiction, or if they develop withdrawal symptoms. As a general rule, if clients need detoxification, they will also need continued treatment and participation in a self-help program (Daley & Moss, 2002).

Restoring physical health may require medical treatment in addition to a healthy diet, reduced sugar, caffeine, and nicotine; adequate rest and relaxation; and exercise. Chemical dependency is associated with a large number of medical problems therefore each client should have a physical examination. Any additional support groups or self-help groups related to eating disorders and the like could benefit the client at this time.

Persons in recovery often experience cravings for alcohol or drugs in the early phases of treatment. There are many things in the environment that can trigger these cravings. Client needs to learn how to handle these feelings. In order to manage and control these cravings, it could be helpful to offer cognitive and behavioral coping strategies to the client.

Psychological and behavioral recovery requires overcoming denial of chemical dependency and accepting one's inability to consistently control substance use. The

primary issue in recovery is denial. Many of the necessary changes can not be obtained if clients do not work through their denial. The first of the Twelve Steps encourages the chemically dependent person to accept being powerless over alcohol (AA) and other drugs (NA) and to admit that their chemical use has made life unmanageable.

Clients must develop a desire for abstinence and establish a need for long-term recovery and support. They are often unsure about abstinence in the beginning phases of recovery and often look for a quick way of dealing with this problem. At first, they become involved in their treatment because of pressures exerted by outside forces. A key issue in accepting the need for long-term recovery is working through their grief. Clients experience a great sense of loss when they give up drugs or alcohol. They have not only made changes in their lifestyle, they have also given up their main way of coping with problems, stress, and pain. This loss contributes to their feelings of fear and uncertainty about their ability to cope with sobriety (Marlatt & Gordon, 1985).

Recovery brings about a wide range of emotions the client needs to learn to deal with. In the early stages of recovery, the client may experience overwhelming and uncomfortable depression and anxiety. As a counselor, it is important to be aware that these negative emotions are the biggest cause of relapse in the chemically dependent. Restoring emotional stability and learning to cope with uncomfortable emotional states is extremely important in the recovery process.

Clients are encouraged to taking a personal inventory of their strengths and liabilities. The goal of this activity is to build their personal assets and correct their liabilities. Problematic personality characteristics are called "character defects." The Twelve Step program emphasizes the need to change these character defects as a part of

recovery (Alcoholics Anonymous, 2001). This inventory also evaluates parts of the client's personality that may need to be changed as a result of a personality disorder. It is important to keep in mind that such changes are long-term and require effort by the individual and help from a professional, sponsor, or both.

In addition to the personal inventory, it can be beneficial for the client to look at the effects their disorder has had on their life and their relationships. This assessment shows the severity of their addiction and it also reduces denial. Direct connections can be seen between substance use and psychiatric, psychosocial, and medical problems. This activity provides an incentive to work at recovery and motivates the client to involve their family in the recovery process (McKlellan, Luborsky, Cacciola, Griffith, Evans, Barr, & O'Brien, 1985).

Clients in recovery must work to change their beliefs and thoughts. "Stinking thinking" is what self-help groups call the connection between distorted thoughts and emotional problems. Cognitive interventions can help clients to make psychological changes by challenging distorted thoughts about their ability to remain sober, their future, their depressed moods, and their interpersonal problems. These strategies have been successful in treating a variety of mood, anxiety, and personality disorders.

In addition, clients need to establish a chemically free sense of identity. The idea of being clean or straight often causes the client to feel uncomfortable. It is necessary to help the client adjust to their new identity as recovering alcoholic or drug addict.

Finally, the client must develop a plan for relapse prevention and long-term recovery. Outcome studies conducted by Marlatt, Gordon, and Daley (1990) indicate that

most chemically dependent people relapse at least once and many relapse frequently. Rates of relapse in psychiatric disorders are also high. Reports suggest that both chemical and psychiatric relapses decrease in frequency and severity when the client participates in treatment devoted to preventing relapse.

Social and family recovery involves overcoming the denial of the impact dual disorders has had on the family. The client must understand how the family and the individual members have been affected by their disorders. This also involves seeing how the family may have enabled the client by taking over their responsibilities and shielding them from the consequences of their use. Clients need to make amends to family and significant others negatively affects by the dual disorders. Making amends may heal some of the damage that has been caused from using or from problematic behaviors that resulted from the use and improve family relationships. Clients can restore or improve important relationships by involving the family in the recovery. Many clients need to learn ways to increase the time they spend with their family, spouses, or children (Daley & Moss, 2002).

Social recovery means developing a recovery support system. A network of other recovering people, friends, and family members is invaluable for helping those in recovery. The counselor can work to make the client aware that others will be more willing to provide support if the clients have made amends and if the relationship is reciprocal.

People in recovery need to find new activities that do not revolve around drugs and alcohol. Since addictions often diminish a person's ability to experience pleasure in life, the client may need to learn how to decrease their need for excitement. They will

have to learn to find pleasure in normal day-to-day activities and learn to resist direct and indirect social pressures to use alcohol and other drugs. Clients need to cope with the temptation to use and resist offers. Clients need to minimize the social pressure by informing others about their recovery and desire to abstain. Clients with social problems caused or exacerbated by the chemical dependency may need help with the problems associated with drug use such as education, occupation, legal, housing, and financial matters. Before addressing these issues prematurely it is helpful to make sure the client has abstained for a period of time.

Spiritual recovery involves resolving feelings of guilt and shame, developing a meaning in life, restoring positive values, developing a relationship with a "Higher Power" or a belief in something greater than oneself, and helping others who suffer from chemical dependency or psychiatric illness. Many dual disordered clients find these steps to spiritual recovery the key to successful recovery. The Twelve Step program provides a mechanism for the client to feel good about them self and maintain their recovery (Daley & Moss, 2002).

Conclusion

The research established in this review regarding dual disorders indicates the complexity of assessment, diagnosis, and treatment for clients who suffer from substance dependency and depression. Although there continue to be questions regarding the prevalence of dual disorders and the effectiveness of specific interventions and integrated treatment, history has shown the coordination of chemical health and mental health systems effectively addresses the needs of the dually diagnosed and improves the treatment outcomes for this population. It is crucial that counselors working with dually

diagnosed clients are familiar with and continue to become educated about the evolving treatment strategies and systems of care. It is clear that additional research is needed in order to develop treatment protocols that yield effective diagnostic, treatment and recovery outcomes. To provide a comprehensive examination of dual disorders, the next and final chapter of this research paper will provide a summary and critical analysis of the information obtained in the literature review and will offer recommendations to counselors working with clients suffering from chemical dependency and depression.

CHAPTER 3: DISCUSSION

Introduction

This chapter presents a summary of the information obtained in the literature review. A critical analysis is included regarding the history of dual diagnosis, the relationship between chemical dependency and depression, three perspectives on dual disorders, assessment and diagnosis of chemical dependency and depression, and integrated treatment for dual disorders. Lastly, the chapter offers recommendations to counselors working with clients suffering from chemical dependency and depression.

Summary

Within the relatively new field of dual diagnosis lies a great deal of uncertainty. For the past twenty years researchers have been working to understand the complexities of dual disorders. Increasing awareness and research regarding dual disorders has occurred because clients tend to use more psychiatric services due to the high prevalence of substance use disorders in person with severe mental illness, the wide- ranging negative effects of substance abuse on the course of illness, and the high cost of treatment for dually diagnosed clients. While increased awareness and research has led to the integration of mental health and chemical dependency programs which focus on new methods and interventions to address both conditions, there remains a need to develop evidence based strategies and treatment protocols for treating individuals with dual disorders.

Dual diagnosis treatment interventions and treatment programs began in 1984. A project that included formal cross-training and cross-systems program development was jointly initiated by the split bureaus in 1993 (Sciacca & Thompson, 1996). It

demonstrated that continuity of care across systems, including trained professionals from a variety of disciplines, is attainable and results in improved, less costly services for the dually diagnosed. However, this project has never been replicated. This history demonstrates a lack of invested leadership at a national level that is capable of developing an organized and consistent agenda for dual disorders. In order to change the course of this history and to fully meet the needs of dually diagnosed consumers and their families there is a need for advocacy at various levels to generate a national consensus for continuing research and modification of service models, programs, and strategies that might yield improved outcomes.

Individuals with dual disorders vary greatly in many ways including: number and types of diagnoses, severity of substance abuse and extent of psychiatric impairment, the number and types of psychosocial problems, availability of social support systems, levels of motivation, and personal strengths (Daley & Moss, 2002). There are many possible explanations for the co-occurrence between chemical dependency and depression. People with dual disorders are frequently misidentified because diagnosis is difficult due to one disorder mimicking the other. It is important for counselors to prepare for many different areas of services to clients including assessment, treatment, referral, and advocacy as well as be aware of all available community resources.

There are a variety of symptoms that occur with depression and chemical dependency. Symptoms of depression include depressed mood, diminished interest or pleasure in activities, significant weight change, change in appetite and sleeping patterns, fatigue, feelings of worthlessness, diminished ability to think or concentrate, and recurrent thoughts of death or suicidal ideation. Symptoms of chemical dependency

include tolerance, withdrawal, unsuccessful efforts to cut down or control use, increased time is spent obtaining or using the substance or recovering from its effects, reduced time spent on important activities because of substance use and continued use despite the knowledge that the problem is likely to have been caused by or exacerbated by the substance use.

There are several assessment issues involved with diagnosing both chemical dependency and depression. Dual disorders are often undiagnosed by professionals who specialize in serving distinct populations. In addition, individuals with dual disorders are frequently misidentified because diagnosis is difficult due to one disorder mimicking the other. A comprehensive assessment must be completed by using a variety of methods. It is important to be aware of the possibility that the client may have not one but two or more serious disorders and to be familiar with treatment options, community resources and effective, research based strategies for this population

Effective treatment of dual disorders integrates mental health and substance abuse intervention. Specifically, having the same clinician or team address depression and chemical dependency issues in a coordinated effort with all interventions taking place in the same setting has been shown to have positive outcomes. Further, depression and chemical dependence have been found to respond well to treatment using a variety of pharmacological and psychosocial treatments, especially cognitive-behavioral and interpersonal psychotherapy. Despite what has been found to be effective in treating depression and chemical dependency, there is still a lack of treatment resources using this comprehensive approach which integrates mental health and addiction treatment in a single program design.

Critical Analysis

There are several questions this study attempts to address. The following is a critical analysis of the research areas proposed.

1. The relationship between chemical dependency and depression.

There are many possible explanations for the co-occurrence of chemical dependency and depression. Cause and effect within co-occurring disorders is often not possible to distinguish. Dual disorders can develop independently at different times. However it is also possible that chemical dependency increases the risk of developing depression or depression may increase the risk for developing chemical dependency. Symptoms of one disorder may mask or exacerbate the symptoms of the other disorder. Depression, for example, may be the result of negative consequences of substance use and over time symptoms may become linked or interrelated (Daley & Moss, 2002).

Research on co-occurring disorders in community and clinical studies indicates that counselors should expect dual disorders rather than consider them an exception. It is important for counselors to consider both disorders to be primary and treated simultaneously in order to obtain positive treatment outcomes. Untreated chemical dependency may contribute to a relapse of depression and depression may contribute to alcohol or drug relapse (Minkoff, 2001).

2. Assessment and diagnosis of chemical dependency and depression.

Substance abuse complicates almost every aspect of a person's life with depression. Many of the symptoms of substance abuse are similar to those of depression. In addition, clients may self medicate to combat symptoms of their depression. The national co-morbidity study found that participants with any substance use disorder also had a

lifetime history of at least one mental health disorder with the second most common diagnosis being major depression (Kessler et al., 1998).

There are several issues in the assessment and diagnosis of individuals suffering from both chemical dependency and depression. Those with dual disorders are frequently misidentified because of the interplay between the two disorders. A comprehensive assessment is necessary in order to determine a diagnosis and set appropriate treatment goals. This assessment must examine a client's total ability to function which includes a thorough substance abuse history as well as medical, psychological, family, educational, occupational, legal, spiritual, social, interpersonal, and recreational functioning. Counselors completing the assessment must be familiar with the multi-axial system of diagnosis as well as the numerous tools which can be used to determine baseline behavior and track changes over time (Daley & Moss, 2002).

3. *Perspectives on Depression and Chemical Dependency: Client, Family, Counselor*

In order to adequately address the needs of the client and fully understand the impact of dual disorders, it is important to be aware of the client, family and counselor perspectives of dual disorders. Clients with dual disorders often have a great deal of difficulty with daily functioning. They may have trouble maintaining employment, living independently or developing relationships with others. In addition, these clients often get caught up in a vicious cycle of failure and frustration. The cycle begins when they enter treatment for either mental health or chemical dependency treatment system. Because these patients are difficult to treat they may evoke negative reactions from treatment providers. Clients who have difficulty maintaining sobriety are discharged from treatment even if they are exhibiting serious psychiatric symptoms. These clients eventually

become so debilitated they are forced to seek help. They enter the treatment system again where they experience the same cycle of failure and frustration (Daley & Moss, 2002).

Dual disordered individuals pose a significant burden for the family. The impact depends on a variety of factors such as severity of the disorders, length of time the family has been exposed to the disorders, the behaviors of the client, the relationships of the family members, and the perceptions and feelings that family members have about the situation. Regardless of the situation, dual disorders can affect any area of family functioning which may result in the family feeling tired, burned out and hopeless. It is extremely important, as a counselor, to be sensitive to these issues and acknowledge that families may have had frustrating experiences with treatment systems which have created a level of mistrust for professionals in treatment agencies (Daley & Sinberg, 1989).

There is an emerging body of research focused on the impact of dual disorders on the family as well has how to address the needs of the family over the course of treatment. As a counselor it is important to appreciate that many families have shown tremendous resiliency and resourcefulness in dealing with their family member. It may be helpful for assessment to focus on the family's strengths as well as their needs. Utilizing a strength-based approach with the family which builds upon strengths rather than simply focus on problem areas may be helpful.

Counselors trained in chemical dependency or mental health disorders are more experienced in treating alcoholics and addicts or clients with severe psychiatric symptoms. Daley & Moss (2002) describe the importance of counselors being aware of personal limitations and their role in the assessment, treatment, referral and advocacy of the client. In addition, being aware of the various resources available in the community

regardless of training and experience is helpful. Professional enabling occurs when counselors fail to address their lack of knowledge or skill and/or have negative attitudes and perceptions about certain conditions or certain patients. This enabling can contribute to the perpetuation of a client's illness. To avoid engaging in this practice, counselors may consider gathering a detailed history of both disorders, address them both in the treatment plan, avoid making assumptions, include the family throughout the entire treatment, and be receptive to a variety of treatment strategies.

4. *Integrated Treatment, Counseling Interventions, and Recovery in Dual Disorders*

Clients with dual disorders have poorer treatment outcomes than those with single disorders. Effective treatment of dual disorders integrates mental health and substance abuse intervention, views both disorders as primary and simultaneously addresses both disorders throughout the course of treatment by persons with expertise in both disorders.

Integrated treatment consists of eight essential components. Drake et al. (2001) describe these critical components of effective intervention; 1) staged intervention involves forming a trusting relationship, helping the client develop the motivation to become involved in recovery oriented intervention, helping the client acquire skills and supports for controlling illness and pursuing goals, and helping the client develop and use strategies for maintaining recovery, 2) assertive outreach works to engage clients and their support system through intensive case management which assists clients to gain access to services and maintain relationships with a consistent program over time, 3) motivational interventions help client with self management and goal setting, 4) active treatment counseling promotes cognitive and behavioral skills which will assist the client in controlling symptoms and maintaining sobriety, 5) social support interventions work to

strengthen the immediate social environment and assist the client to modify their behavior, 6) a long-term, community based perspective includes rehabilitation activities to prevent relapses and to enhance gains for increased client stability, 7) cultural sensitivity and competence is critical to engaging clients. Services can be tailored to particular racial, cultural and other group characteristics and 8) a comprehensive treatment system that does not isolate interventions for either disorder.

While there have been methodological limitations to several research studies on integrated treatment, the outcome remains that current integrated treatment programs are more effective that nonintegrated programs. Further, several components of integrated treatment programs can be considered evidence based because they are almost always present in programs that have demonstrated positive outcomes in controlled setting studies and because their absence is associated with failures. Regardless of inconsistencies across research studies, integrated treatment has been found to be the most effective form of treatment for dual disorders.

Several barriers have been identified by Drake et al. (2001) as limitations of the research on integrated treatment. Implementation barriers are common as a result of integrated dual diagnosis services and other evidence-based practices are advocated but not offered in mental health treatment settings. Policy barriers occur as state, county, and city mental health authorities encounter policies related to organizational structure, financing, regulations, and licensing which oppose the functional integration of mental health and substance abuse services. Program barriers at the local level appear through the lack of service models, administrative guidelines, contract incentives, quality assurance procedures and outcome measures needed to implement dual diagnosis

services. Clinical barriers take place due to traditional beliefs, education and training of clinicians. While the integrated clinical philosophy and approach to dual diagnosis has been delineated, educational institution are not teaching this approach. This lack of training in dual diagnosis treatment forces clinicians to rely on themselves to obtain information on current interventions. Lastly, consumer and family barriers occur due to few programs offering psycho-educational services related to dual diagnosis; thus clients and their families remain without proper information about dual diagnosis and appropriate services. Future research can identify proven strategies for overcoming these aforementioned barriers and make a significant contribution to the research and effective treatment of dual disorders.

Limitations of the Study

A limitation of this study is that field of dual diagnosis is still evolving and current research specific to dual disorders is limited compared to many other mental health disorders. Research thus far has studied the clinical aspects and treatment programs, yet there is a need for research and examination of policy or systems perspectives related to dual diagnosis.

Recommendations

The purpose of this study is to provide counselors detailed information on dual disorders as well as psychotherapeutic strategies and counseling interventions which have yielded positive outcomes for clients who suffer from chemical dependency and depression. The following recommendations are given as a result of this literature review and critical analysis:

1. It is recommended that counselors use a collaborative, team approach involving clinicians with expertise in each area of functioning affected by both disorders. In addition, all team members should be cross trained for full understanding of dual disorders.
2. It is recommended that counselors use a multimodal method of psychological observations, interviews, questionnaires, surveys, neuropsychological tests, physical examinations, and/or laboratory tests to obtain baseline data and track symptom and behavior changes over time.
3. It is recommended that counselors familiarize themselves on all areas of treatment including assessment, treatment, referral, and advocacy. More specifically, the counselor needs to be aware of all available resources in the community such as treatment centers, self-help groups, social and case management, economic assistance, housing, and vocational training.
4. It is recommended that counselors use a variety of psychotherapeutic strategies and counseling interventions when implementing a treatment plan.
5. It is recommended that counselors identify the impact of dual disorders on the family and work to address the family needs as well as that of the client in order to obtain positive treatment outcomes.
6. It is recommended that additional research is conducted regarding effective and evidence based psychotherapeutic strategies and counseling interventions counselors can use when treating a client who is diagnosed with a particular mental disorder(s) and chemical dependency.

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